



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MIGUEL A BERASTAIN MD
7121 SPID #106
CORPUS CHRISTI TX 78412

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #: 9

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3239-01

MFDR Date Received

MAY 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Surgery performed in an ER basis for intractable left hand pain with a crushed injury. Hypertension was the secondary Dx."

Amount in Dispute: \$2,463.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. Texas Mutual maintains its position the surgery required preauthorization and none was obtained. No payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2010	CPT Codes 26530 and 64721	\$2,463.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits were not submitted by either party.

Issues

1. Did the requestor file the Request for Medical Fee Dispute Resolution in accordance with 28 Texas Administrative Code §133.307?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(1)(A) date of service May 18, 2010 did not involve issues of compensability, extent of injury or medical necessity; therefore, this date of service was not submitted within one year after the date of service in dispute and cannot be reviewed by Medical Fee Dispute Resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	June 6, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.